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SAVE THE DATE • MAY 1–2, 2014
SPRING
TASK FORCE
SUMMIT
KANSAS CITY, MO

ALEC American Legislative Exchange Council

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35-Day Mailing

Health & Human Services Task Force

ALEC American Legislative Exchange Council

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MEMORANDUM

TO: HEALTH AND HUMAN SERVICES TASK FORCE MEMBERS
FROM: SEAN RILEY, DIRECTOR, HEALTH AND HUMAN SERVICES TASK FORCE
RE: 35-DAY MAILING—ALEC'S SPRING TASK FORCE SUMMIT
DATE: MARCH 28, 2014

The American Legislative Exchange Council will host its Spring Task Force Summit May 1-2 at the Kansas City Marriott Downtown in Kansas City, Missouri. If you have not yet registered, the Spring Task Force Summit agenda, registration, and hotel information are available online. Please note that the cut-off for early registration and hotel reservations is April 4th.

All HHS Task Force members should plan on attending the following on ***Friday, May 2nd:***

10:00 to 11:00 a.m.	***Discussion on Telemedicine and the States***
12:30 to 1:30 p.m.	***HHS Task Force Luncheon***
2:00 to 5:00 p.m.	***HHS Task Force Meeting***
5:30 to 7:00 p.m.	***Kansas City Reception***

Additionally, please find the following HHS briefing materials enclosed:

- Attendee Registration Form
- Schedule of Events
- HHS Task Force Meeting Tentative Agenda
- Proposed Model Policy for Consideration
- Sunset Review Materials
- Reimbursement Policies by Meeting
- ALEC Mission Statement

As a reminder, the attached proposed model policy is not official ALEC model policy until it passes both the HHS Task Force and the ALEC National Board of Directors.

I look forward to seeing you all in Kansas City for what is sure to be a productive and informative meeting. If you have any questions or feedback on proposed model policy or the agenda, please do not hesitate to contact me at (202) 309-1274, or at sriley@alec.org.

Best regards,

Sean Riley
Director, Health and Human Services Task Force
American Legislative Exchange Council

2014 ALEC SPRING TASK FORCE SUMMIT

May 1 - 2, 2014

Kansas City Marriott Downtown
200 W 12th St ● Kansas City, MO 64105

ATTENDEE REGISTRATION / HOUSING FORM

Early registration deadline: April 4, 2014
Housing cut-off date: April 4, 2014

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Online www.alec.org **Email** meetings@alec.org **Fax** 703.373.0932 **Phone / Questions** 571.482.5056 (Mon-Fri, 9am-5pm EST)

ATTENDEE INFORMATION

Prefix _____ First Name _____ Middle Initial _____ Last Name _____ Suffix(s) : _____
Badge Nickname: _____ Title _____
Organization *(required)* _____
Preferred Mailing Address: □ Business □ Home _____
City _____ State/Province _____ Country _____ ZIP/Postal code _____
Preferred Phone □ Work □ Home □ Mobile _____ Alternate phone □ Work □ Home □ Mobile _____ Fax _____
Email *(confirmation will be sent by email)* _____
On-site Emergency Information Name of Person to Contact: _____ Phone _____ Relationship to You: _____
Do you have any special physical, dietary (for example, vegetarian, kosher), or other needs: ❑ Yes ❑ No
If yes, please describe: _____
❑ This is my first time attending an ALEC event.

***Spouse / Guest:** If registering a spouse or guest, please complete the spouse/guest registration form. Spouse / guest registration is meant to accommodate legal spouses and immediate family members. Attendees from the same organization must register independently.

REGISTRATION INFORMATION

*** Please note that member fees are subject to verification*

	EARLY until April 4	*ON-SITE begin April 5*
□ ALEC Legislative Task Force Member	$ 150	$ 150
□ ALEC Private Sector Task Force Voting Member	$ 275	$ 275
□ ALEC Non-Profit Task Force Voting Member	$ 275	$ 275
□ ALEC Legislative Member/ Non-Task Force Member	$ 300	$ 400
□ Private Sector Member/ Non-Task Force Member	$ 550	$ 650
□ ALEC Non-Profit Member (501(c)(3) status required)/ Non-Task Force Member	$ 475	$ 575
□ Legislative/ Non-Member	$ 400	$ 500
□ Private Sector/ Non-Member	$ 675	$ 825
□ Non-Profit Non-Member (501(c)(3) status required)	$ 625	$ 725
□ Legislative Staff/ Government	$ 400	$ 500
□ ALEC Alumni	$ 350	$ 450
□ ALEC Legacy Member	$0	$0

METHOD OF REGISTRATION PAYMENT

Credit Card: Credit cards will be charged immediately.
□ Amer Express □ Visa □ MasterCard
Card # _____
Cardholder *(please print)* _____
Exp Date *(mm/yy)* _____ Security Code_____
Signature _____

REGISTRATION CANCELLATION / REFUND INFORMATION

Registrations cancelled prior to 5pm EST April 4, 2014 are subject to a $100 cancellation fee. Registrations are non-refundable after 5pm EST April 4, 2014.

REGISTRATION FEES: $ _____

Note: Registration forms with enclosed payments must be received by April 4, 2014 to be eligible for early bird registration rates. Forms and/or payments received after April 4, 2014 will be subject to the on-site registration rate.

REGISTRATION CONFIRMATION INFORMATION

Online registrants will receive immediate email confirmation. If registering by form, confirmation will be emailed, faxed, or mailed within 72 hours of receipt of payment.

HOUSING — RESERVATION CUTOFF FOR ALEC DISCOUNTED RATE IS April 4, 2014

Kansas City Marriott Downtown **Arrival Date** _____ **Departure Date** _____

Sharing with: (Maximum 4 guests per room)
_____

Room Type

□ Single	(1 person – 1 bed)	$149
□ Double	(2 persons – 1 bed)	$149
□ Double/ Double	(2 persons – 2 beds)	$149
□ Triple	(3 persons – 2 beds)	$149
□ Quad	(4 persons – 2 beds)	$149

Special requests
□ ADA room required:
☐ Audio ☐ Visual ☐ Mobile
□ Rollaway / crib: _____
□ Other: _____
_____

Credit Card Information/ Reservation Guarantee

Credit Card information is required at time of reservation to guarantee the reservation. Card must be valid through December 2014.

□ Please use the same credit card information as above.
□ Amer Express □ Visa □ MasterCard □ Discover
Card # _____
Cardholder *(please print)* _____
Exp Date *(mm/yy)* _____ Security Code_____
Signature _____

Room types and special requests are not guaranteed.
All rates DO NOT include city development fee $1.75 and room tax currently 16.85% (subject to change)
Note: Cutoff for reservations at the ALEC rate is April 4, 2014. After April 4, 2014, every effort will be made to accommodate new reservations, based on availability and rate. The hotel will assign specific room types at check in, based upon availability.

HOUSING CONFIRMATION INFORMATION

Online reservations will receive immediate email confirmation. Reservations received by form will be confirmed via email, fax, or mail within 72 hours of receipt.

HOUSING CANCELLATION / REFUND INFORMATION

Credit cards will be charged one night room and tax in the event of a no show or if cancellation occurs within 72 hours prior to arrival. Please obtain a cancellation

2014 ALEC SPRING TASK FORCE SUMMIT

May 1 - 2, 2014
Kansas City Marriott Downtown
200 W 12th St ● Kansas City, MO 64105

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SPOUSE/GUEST REGISTRATION FORM

Online www.alec.org | **Fax** (*credit cards only*) 703.373.0932 | **Phone / Questions** ● Mon-Fri, 9am-5:00 pm EST 571.482.5056

ATTENDEE INFORMATION IS REQUIRED TO REGISTER A SPOUSE OR GUEST

First Name _____ Last Name _____

Organization_____

Daytime phone_____

Email (*Confirmation will be sent by email)* _____

SPOUSE / GUEST REGISTRATION

SPOUSE / GUEST REGISTRATION GUIDELINES

1. Spouse / guest registration is meant to accommodate legal spouse and immediate family members.
2. Attendees from the same organization must register independently. No exception will be made.
3. Spouse / guest designation will be clearly visible on name badge.

Prefix _____Last Name _____ First Name _____ Middle initial _____ Badge Nickname _____

Prefix _____Last Name _____ First Name _____ Middle initial _____ Badge Nickname _____

Prefix _____Last Name _____ First Name _____ Middle initial _____ Badge Nickname _____

SPOUSE / GUEST REGISTRATION FEES	***Number of Spouse/Guest(s)***	***Fee***	***TOTAL***
□ Spouse / Guest *please note name(s) above*	_____	$ 50	$ _____

METHOD OF SPOUSE / GUEST REGISTRATION PAYMENT
Credit Card: Credit cards will be charged immediately. Please fax to the above number for processing.

□ Amer Express
□ Visa
□ MasterCard

Card # _____
Cardholder *(please print)* _____
Exp Date *(mm/yy)* _____/_____ Security Code _____
Signature _____

REGISTRATION CONFIRMATION INFORMATION
Online registrants will receive immediate email confirmation. If registering by form, confirmation will be emailed within 72 hours of receipt of payment.

REGISTRATION CANCELLATION / REFUND INFORMATION
Registrations are non-refundable after 5pm EST April 4, 2014.

2014 Spring Task Force Summit Schedule of Events

Friday, May 2nd, 2014

9am – 12pm Subcommittee Meetings

12:30pm – 1:30pm Task Force Luncheons

2pm- 5pm Task Force Meetings

5:30pm – 7pm Kansas City Reception

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Health and Human Services Task Force Meeting | Spring Task Force Summit
Friday, May 2, 2014
2:00 - 5:00 p.m.

TENTATIVE AGENDA

2:00 p.m. CALL TO ORDER

Welcoming Remarks
Senator Judson Hill, Georgia, HHS Public Sector Chair
Marianne Eterno, Guarantee Trust Life Insurance, HHS Private Sector Chair

Introduction of Task Force Members and Guests
Approval of Minutes

2:15 p.m. SPECIAL PRESENTATIONS AND DICUSSION

State of the States
Current Status of Federal Health Reform
Update on Outstanding ACA Lawsuits
Combatting Fraud, Waste, and Abuse
Medicaid and the Private Option
Issues Facing Providers

3:45 p.m. PROPOSED MODEL POLICY: DISCUSSION AND VOTING

Patient Access Expansion Act

4:05 p.m. SUNSET REVIEW

Resolution on Federal Health Insurance Exchanges and a Public Plan
Resolution on Certificate of Need (CON) Laws
Patient's Right to Know Act
Resolution on Autism Coverage
Optional Medicaid Benefits Evaluation Act
Resolution on Cord and Placenta Blood Banking Research
Patients First Medicaid Reform Act
Resolution on Improving Quality and Lowering Costs Through Medicaid Managed Care
Unintended Consequences Prevention Act

5:00 p.m. GOOD OF THE ORDER/ADJOURNMENT

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Proposed Model Policy

Health & Human Services Task Force

Patient Access Expansion Act

Patient Access Expansion Act
(DRAFT, May 2, 2014)

Background

Physicians are thoroughly tested and re-tested during medical school and residency training. In addition to this testing, each medical board sets its own requirements for Continuous Medical Education (CME), which may vary from 0 hours to 50 hours per year. While these testing and educational requirements are fundamental and essential, additional requirements, such as Maintenance of Licensure (MOL) and Maintenance of Certification (MOC), are expensive, unnecessary, and are not shown to be effective in improving the quality of medical care.

Summary

This act prohibits the state from requiring any form of Proprietary Maintenance of Licensure tied to Maintenance of Certification or any Specialty Board Certification and/or Maintenance of Certification in order to practice medicine within the state.

Model Policy

Section 1. Title. This Act shall be known as the "Patient Access Expansion Act."

Section 2. Definitions.

(A) As used in this Act:

(1) "Maintenance of Licensure" (MOL) shall mean the framework for medical license renewal, including additional periodic testing. State Medical Boards currently do not require MOL.

(2) "Continuous Medical Education" (CME) shall mean continued postgraduate medical education intended to provide medical professionals with knowledge of new developments in their field.

(3) "Specialty Medical Board Certification" (SMBC) shall mean certification by a board that specializes in one particular area of medicine and typically requires additional and more strenuous exams than state boards of medicine requirements to practice medicine.

(4) "Maintenance of Certification" (MOC) shall mean a process to keep Specialty Medical Certification continuous through periodic re-certification exams.

Section 3. Prohibition of Maintenance of Licensure.

{Insert state} is prohibited from requiring any form of Proprietary Maintenance of Licensure tied to Maintenance of Certification in order to practice medicine within the state. Current requirements, including CME, shall suffice to demonstrate professional competency.

Section 4. Prohibition of Maintenance of Certification (Specialty Board Certification and Re-certification) to Practice Medicine.

{Insert state} is prohibited from requiring any form of Specialty Board Certification and/or Maintenance of Certification to practice medicine within the state. Within the state, there shall be no discrimination by the state medical board (or any other agency or facility which accepts state funds) against physicians who do not maintain specialty medical board re-certification.

Section 5. Severability Clause.

Section 6. Repealer Clause.

Section 7. Effective Date.

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Sunset Review

Health & Human Services Task Force

Patient's Right to Know Act
Resolution on CON Laws Required for the Establishment of Certain Health Care Services
Resolution on Preserving States' Rights Regarding Federal Health Insurance Exchanges and a Public Plan

Optional Medicaid Benefits Evaluation Act
Patients First Medicaid Reform Act
Resolution on Autism Coverage
Resolution on Cord and Placenta Blood Banking and Research
Resolution on Improving Quality and Lowering Costs Through Medicaid and Managed Care
Unintended Consequences Prevention Act

Patient's Right to Know Act

Summary

This act requires health care providers to provide estimated charges to patients, upon request, if a patient is referred to, or under care of a provider. Additionally, this act requires insurers and self-insured health plans to provide coverage information, pre-authorization requirements, limitation information, and discount information to the insured, or an insured's agent upon request.

Model Legislation

Section 1. Title. This Act shall be known as the "Patient's Right to Know Act."

Section 2. Purpose. The purpose of this legislation is to provide health care consumers with better information on the cost of their medical care and to introduce elements of competition into the marketplace.

Section 3. Applicability and Scope. This legislation shall apply to all providers of medical care in this state, and any health maintenance organization or health insurer conducting business in this state, and self-insured health plans offered by any unit of government in this state.

Section 4. Definitions. As used in this Act, the following definitions apply:

A. "Ambulatory Surgical Center" has the meaning given in federal law (42 CFR 416.2).

B. "Average paid rate" means the average amount that a health care provider currently accepts as payment in full for a health care service, diagnostic test, or procedure, after any discount applicable to certain patients is applied.

C. "Charged rate" means the average, median, or actual amount that is currently charged by a health care provider to a patient for a health care service, diagnostic test, or procedure.

D. "Clinic" means a place, other than a residence, that is used primarily for the provision of nursing, medical, podiatric, dental, chiropractic, or optometric care and treatment.

E. "Cost-sharing requirements" means copayments, deductibles, coinsurance percentages, and any other cost-sharing mechanisms that apply under a health care plan or self-insured health plan.

F. "Course of treatment" means, as part of a health care service, the management and care, including related therapy and rehabilitation, of a patient over time for the purpose of combating disease or disorder or temporarily or permanently relieving symptoms.

G. "Health care plan" means health insurance plans offered by entities specified in Section 3.

H. "Health care provider" or "provider" means providers of medical care in this state and includes a clinic and an ambulatory surgery center.

I. "Health care service," "diagnostic test," or "procedure" includes physical therapy, speech therapy, occupational therapy, chiropractic treatment, or mental therapy, but does not include a prescription drug.

J. "Insured" means covered under a health care plan offered by an insurer or under a self-insured health plan.

K. "Insured's agent" means a parent, guardian, or legal custodian of an insured who is a minor child; the spouse of an insured; an agent of an insured under a valid power of attorney for health care; a guardian of the person, or anyone authorized by an insured to act as his or her agent.

L. "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance and is included in Section 3.

M. "Mental therapy" includes services and treatment for mental illness, developmental disability, alcohol and other drug abuse, and drug dependence.

N. "Minimum cost" means $500 or any higher amount that is specified by departmental rule that adjusts for inflation.

O. "Out-of network" means any treatment received from a medical care provider that is not a member of the patient's preferred network.

P. "Patient's agent" means the parent, guardian, or legal custodian of a minor patient; the spouse of a patient; an agent of a patient under a valid power of attorney for health care; a guardian of the person, or any individual who is authorized by the patient to act as his or her agent.

Section 5. Disclosures Required of Health Care Providers. If a patient is recommended to, referred to, or is under the care of a health care provider or group of health care providers for a health care service, including any applicable course of treatment, or diagnostic test or procedure for which the charge exceeds the minimum cost, and if the patient or the patient's agent requests an estimate of the charge, the health care provider or group of health care providers, if applicable, shall provide the patient or the patient's agent with an estimate of the charge of the provider and provider groups as used in this Section.

A. Except as provided in Paragraph B, an estimate of the charge shall provide the following, as applicable, at the time of scheduling of the health care service, diagnostic test, procedure, or course of treatment or within 10 business days of the request, whichever is later:

    1. For an inpatient surgical procedure and course of treatment, an estimate of the charge that shall include all of the following:

a. The reasonably anticipated services of health care providers who will likely provide health care services, during and after the surgical procedure and during any related course of treatment.

b. The reasonably anticipated total charge for hospitalization, daily charge for hospitalization, and number of days of hospital stay.

2. For an outpatient surgical procedure and course of treatment, an estimate of the charge that shall include the reasonably anticipated total charge.

3. For a nonsurgical hospital procedure and course of treatment, an estimate of the charge that shall include the reasonably anticipated services of health care providers who will likely provide health care services during and after the procedure and any related course of treatment.

4. For physical therapy, speech therapy, occupational therapy, chiropractic treatment, or mental therapy, an estimate of the charge that shall include all of the following:

a. A proposed treatment plan that describes the number and frequency of visits of a course of treatment and the anticipated charges for the course of treatment. If the course of treatment is anticipated to exceed 6 months and if the patient or the patient's agent so requests, the health care provider shall provide an estimate of the charge and course of treatment plan for each anticipated 6 month period.

b. Objective quality data that is related to the health outcome of the proposed course of treatment, if the health care provider has made public the data.

B. In lieu of the requirements under Paragraph A, a health care provider or group of health care providers, if applicable, may provide to the patient or the patient's agent an estimate of the charge that is a single fixed-price estimate of the total cost of the health care service, diagnostic test, or procedure.

C. All of the following applies to an estimate of the charge provided under this Section:

1. The estimate of the charge shall represent the good-faith effort of a health care provider or group of health care providers, if applicable, to provide accurate information to the patient or the patient's agent.

2. The estimate of the charge shall inform the patient of his or her responsibilities in complying with any medical requirements for the patient that are associated with any health care service, diagnostic test, or procedure proposed; and the potential of cost variances that are due to factors that cannot reasonably be anticipated.

3. The estimate of the charge shall indicate how the health status of the patient may contribute to any charge variances that may reasonably be anticipated.

4. The estimate of the charge shall include any discounts or financial incentives the health care provider or group of health care providers, if applicable, are

willing to offer to the patient for obtaining a health care service, diagnostic test, or procedure that is provided by the health care provider or group of health care providers.

5. The estimate of the charge shall include a description of the health care service, diagnostic test, or procedure that includes the appropriate medical code or codes that will enable the patient or patient's agent to obtain applicable coverage payment information under Section 6 from an insurer or self-insured health plan.

6. The estimate of the charge shall include the identity of the health care provider or the individual identities of the group of health care providers, if applicable, and the address of the applicable facility with which each health care provider is associated.

7. The estimate of the charge may, if requested by the patient or the patient's agent, be issued electronically.

8. The estimate of the change is not a binding or implied contract upon the parties and is not a guarantee that the amounts estimated will be charged.

9. The estimate of the charge shall contain language that encourages the patient to review the estimate carefully and to contact his or her insurer or self-insured health plan for specific coverage information.

Section 6. Disclosures Required of Health Insurers. An insurer or self-insured health plan shall provide any of the following information if requested by an insured or an insured's agent:

A. A description of the coverage, including benefits and cost-sharing requirements, under the insured's health care plan or self-insured health plan.

B. A description of pre-certification or other requirements, if any, that an insured must complete before any care is approved by the insurer or self-insured health plan.

C. Based on the information relating to an estimate of the charge that was provided to the insured or insured's agent under Section 5, a summary of the insured's coverage with respect to a specific medical service or course of treatment, including all of the following information:

1. The estimated total and type of out-of-pocket costs that the insured may incur, including deductibles, copayments, coinsurance, and items and other charges that are not covered by the insurer or self-insured health plan.

2. An estimate of the amount that the insurer or self-insured health plan paid to a provider or providers for the specific medical procedure or course of treatment. The estimate under this Subparagraph may provide the payment amount or rate in such a way that protects the insurer's proprietary pricing, but shall be a reasonably close estimate of the actual amount or rate paid.

3. Any limits on what the insurer or self-insured health plan will pay if the service or course of treatment is received from an "out-of-network" provider.

If the insured provides to the insurer or self-insured health plan the applicable medical code or codes for the service or course of treatment provided or proposed to be provided by a provider or providers that are not participating, the insurer or self-insured health plan shall inform the insured if the cost of the service or course of treatment exceeds the allowable charge under the insurer's or self-insured health plan's guidelines for payment for the service or course of treatment under the insured's health care plan or self-insured health plan.

4. Any discounts or financial incentives that the insurer or self-insured health plan is willing to offer the insured, including incentives for the insured to obtain care or a course of treatment from a different provider.

5. That the information in the summary is based on the information relating to the estimate of the charge that was provided to the insured or insured's agent under Section 5.

6. That the information in the summary represents only an estimate and is not a legally binding contract or guarantee of the amounts provided in the summary.

D. The information in this Section may be provided to the insured in writing, orally, or electronically, whichever is preferred by the insured.

E. The insurer or self-insured health plan shall make a good faith effort to provide accurate information to the insured under this Section.

Section 7. Initial Applicability. If a health care plan or a governmental self-insured health plan that is in effect on the effective date of this Section, or a contract or agreement between a health care provider and a health care plan that is in effect on the effective date of this Section, contains a provision that is inconsistent with this Act, this Act first applies to that health care plan, governmental self-insured health plan, or contract or agreement on the date on which it is modified, extended, or renewed.

Section 8. {Severability Clause.}

Section 9. {Repealer Clause.}

Section 10. Effective Date. This Act takes effect on the first day of the 25th month beginning after publication.

Adopted by the Health and Human Services Task Force May 1, 2009.

Approved by the American Legislative Exchange Council's Board of Directors June 6, 2009.

Resolution on Certificate of Need (CON) Laws Required for the Establishment of Certain Health Care Services

Summary

This resolution urges states to oppose the establishment, expansion, or existence of government-imposed barriers to health care access such as Certificate of Need (CON) laws.

Model Resolution

WHEREAS, Certificate of Need (CON) laws and similar programs are prominent government-imposed barriers to entry into the health care market that force health care firms to fulfill various over-burdensome requirements to obtain state permission to provide certain services; and

WHEREAS, Government-imposed barriers to entry into the health care market thwart access to quality care and healthy competition by preventing and/or delaying entities from bringing new technologies into certain geographical regions; and

WHEREAS, Barriers to entry stifle competition in the health care arena by not allowing services to follow the demand of patients and payors; and

WHEREAS, The Antitrust Division of the U.S. Department of Justice and the U.S. Federal Trade Commission, in a joint statement, noted that CON laws "impede the efficient performance of health care markets" and "pose serious anticompetitive risks that usually outweigh their purported economic benefits"; and

WHEREAS, CON laws derive their origin from a repealed federal law (The National Planning and Resources Development Act of 1974) that advocated for the establishment of CON laws based on the then-current reimbursement arrangements that have since changed dramatically; and

WHEREAS, Market forces tend to improve the quality of care while lowering the cost of services and lead to innovation in the health care world; and

WHEREAS, The health care system thrives on efficient and effective services that are at odds with the effects of CON laws.

THEREFORE BE IT RESOLVED THAT {insert state} opposes the establishment, expansion, or existence of government-imposed barriers to health care access such as Certificate of Need (CON) laws.

Approved by the Health and Human Services Task Force May 2009

Resolution on Preserving States' Rights Regarding Federal Health Insurance Exchanges and Public Plan

Summary

This resolution urges Congress not to institute new federal review, oversight, or preemption of state health insurance laws and additionally urges Congress not to create a federal health insurance exchange or connector, and not to create a federal health insurance option.

Model Resolution

WHEREAS, The Tenth Amendment to the United States Constitution states that, "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people;" and

WHEREAS, The states primarily regulate today's health insurance market and provide aggressive oversight of all aspects of this market and enforce consumer protection as well as ensure a local, responsive presence for consumers; and

WHEREAS, The state-based system of regulation of health insurance has served all interests well; and

WHEREAS, The U.S. Congress is considering legislation that may impose restriction on the states' ability to regulate health plans, including overriding already adopted state patient protections; and

WHEREAS, The federal government should regulate health plans only where they are given authority under the Employee Retirement Income Security Act (ERISA) and allow the states to continue to regulate all other plans within their borders and with their existing regulatory expertise without federal intervention; and

WHEREAS, The creation of a new federal system of regulation for health insurance would be inefficient, unnecessary, not cost-effective, and an additional burden on the health care delivery system; and

WHEREAS, Private sector health plans are leaders in innovations to improve quality, benefits, and customer service that government-sponsored health plans have been slow to adopt; and

WHEREAS, Congress is considering legislation that would create a federal health insurance exchange or connector to facilitate the purchase of health insurance by individuals and small employers, including offering a new public plan option; and

WHEREAS, A federal exchange would create conflicting state and federal rules, resulting in consumer confusion and leading to adverse selection; and

WHEREAS, A federal exchange would require substantial resources to create a new federal entity that duplicates functions currently performed by states; and

WHEREAS, A federal exchange would undermine states' oversight role in health insurance and cause a substantial shift in the regulation of the health insurance market from the states to the federal government; and

WHEREAS, A federal exchange would undermine state authority to design programs that reflect local needs; and

WHEREAS, A new public plan would not improve competition, but would result in an uneven playing field that would shift costs to the private sector and undermine private plans; and

WHEREAS, A new public health insurance plan would be subject to constant federal changes; and

WHEREAS, A new public plan is unnecessary in light of the private sector's product offerings and innovations.

NOW THEREFORE BE IT RESOLVED THAT the legislature of the state of **{insert state}** urges Congress not to institute new federal review, oversight, or preemption of state health insurance laws; not to create a federal health insurance exchange or connector; and not to create a federal health insurance plan (public plan) option.

BE IT FURTHER RESOLVED THAT copies of this resolution will be distributed to all Governors and all Members of the U.S. Senate and U.S. House of Representatives.

Approved by the Health and Human Services Task Force on May 1, 2009.

Optional Medicaid Benefits Evaluation Act

Summary

This act requires state agencies seeking expanded optional Medicaid benefits to provide funding for an independent third party analysis. Additionally, this act requires approval from oversight committees in both chambers and both houses before proposals proceed, as well as a review of existing optional benefits. This act also outlines analysis requirements, and provides for judicial review.

Model Legislation

Section 1. Title. This Act shall be known as the "Optional Medicaid Benefits Evaluation Act."

Section 2. Definitions.

A. "Medicaid" is the federal Title XIX Medical Assistance program administered by states and funded in part by the federal government.

B. "Independent third party" is a public or private entity or private person having no ongoing financially dependent relationship with the **{insert appropriate state agency},** the Auditor General, or the **{insert name of state Medicaid Agency}**, and that possesses the necessary expertise to conduct the evaluation and/or write the report as described in this Act.

C. "Optional benefits" are medical services potentially or currently provided under the Medicaid program of this state that are categorized as optional by the federal Centers for Medicare & Medicaid Services, including recipient populations that are not required to be covered under federal law.

D. "Report" means a written document that comprehensively records the methods used and results of an evaluation of optional benefits.

E. "Recipient" is an individual who receives benefits under the Medicaid program of this state.

F. "Recipient population" is the group or a sub-group of all individuals or households in the state who receive benefits under the Medicaid program of this state.

Section 3. Evaluations of Proposed and Existing Medicaid Benefits Required.

A. The **{insert appropriate state agency}** shall not promulgate and approve rules, apply for federal waivers, or otherwise take any action that would expand optional benefits under the state's Medicaid program unless the agency:

1. Provides funding to the Auditor General or the **{insert appropriate state agency}** who shall then contract with an independent third party to evaluate the proposed expansion and produce a report as described in this Act; and

2. Presents the proposal and report to the appropriate oversight committees of the legislature for approval to proceed. Majorities of the members of oversight committees from both houses of the legislature must approve the proposal in order for the **{insert appropriate state agency}** to proceed.

B. Legislative oversight committees shall consider if an optional benefits expansion:

1. Creates clear and measurable net economic benefits that accrue generally to all citizens of the state, even in the absence of federal funds;

2. Does not interfere with citizens' ability to engage in free enterprise in the medical industry;

3. Clearly fills a need that only government can fill; and

4. Is not likely to result in a financial obligation to the state that would necessitate a tax increase at some future time.

C. The Auditor General or the **{insert appropriate state agency}** shall contract with one or more independent third parties to evaluate existing optional benefits under the state's Medicaid program. The evaluation and a report of the evaluation shall be completed within two years of the date of passage of this Act and shall meet the requirements set forth in this Act.

Section 4. Evaluation of Optional Benefits. Any evaluation required by this Act shall at least include an analysis of optional benefits' effects on:

A. The health and productivity of the proposed recipient population;

B. The health care prices faced by the non-recipient population;

C. The demand for medical services separately delineated by recipient and non-recipient populations, including demand for medical services not included in the optional benefit(s) being studied;

D. The administrative costs faced by providers of services under the federal Title XIX Medical Assistance program;

E. Health insurance premiums;

F. Emergency room services for recipient and non-recipient populations;

G. The practices and decision of suppliers of health services that would affect the market for medicine and the possible results of those actions; and

H. The state's short- and long-term fiscal outlook including the likelihood of future tax increases to pay for the optional benefits under plausible economic scenarios.

Section 5. Report.

A. A written report shall be prepared by the independent third party describing the evaluation in Section 4 and the methods used to conduct the evaluation. Copies of the written report shall be submitted to the Governor, the presiding officers the legislature, and the members of the relevant oversight committees.

B. The Auditor General **{insert appropriate state agency}** shall review the report for:

1. Completeness;

2. Its adherence to professional standards; and

3. Sound methodology.

Section 6. Judicial Review. A resident taxpayer of the state shall have standing to seek de novo judicial review as to whether the criteria set out in this Act regarding review and approval of an optional benefit have been met by filing an action seeking declaratory, injunctive, quo warranto, or writ of prohibition relief.

Section 7. {Severability Clause.}
Section 8. {Repealer Clause.}
Section 9. {Effective Date.}

Passed by the Health and Human Services Task Force on December 3, 2009.
Approved by the ALEC Board of Directors on January 8, 2010.

Patients First Medicaid Reform Act

Summary

This act establishes Medicaid Savings Accounts under a federal waiver, requiring policies to cover federally mandated Medicaid benefits, while exempting state mandated benefits. Additionally, this act outlines criteria for funding, continuation of benefits, and transparency.

Model Legislation

Section 1. Title. This Act may be cited as the *Patients First Medicaid Reform Act*.

Section 2. Definitions.
A. "Medicaid Savings Account," or "MSA," is an account funded by the **{insert state Medicaid agency}** which can be used for medical expenses and qualifying non-medical expenses as approved by the **{insert state Medicaid agency}**.

Section 3. Federal Waiver. The **{insert state Medicaid agency}** shall seek a Medicaid waiver from the Centers for Medicare and Medicaid Services to receive **{insert percentage}** of federal funding as a five-year block grant.

Section 4. Qualifying Policies.
A. To qualify, a health insurance policy must meet federal requirements for Health Savings Account (HSA) eligibility.

B. Policies must cover federally mandated Medicaid benefits.

C. Policies will be exempt from other state mandated benefits.

D. HSA-eligible policies available through the state or federal high-risk pool are eligible for those individuals who meet enrollment criteria.

Section 5. Establishment of Benefits.
A. The **{insert state Medicaid agency}** shall establish Medical Savings Accounts for Medicaid enrollees or their families with the **{insert state treasurer}** *(Drafting Note: Accounts may also be established with the state employee retirement system, or with private vendors).*[i]

B. The amount deposited in an individual's account shall be equal to the amount required to purchase a qualifying individual or family high-deductible policy and fund a portion of a related HSA.

1. This amount shall be adjusted for age and health status.

2. Funds shall be made available on a pro-rated basis each month.

C. Only high-deductible policies that meet federal requirements to be eligible for an HSA shall be eligible for purchase.

Section 6. Continuation of Benefits.

A. A current Medicaid recipient or guardian who becomes employed may continue to receive premium supports and MSA deposits as long as the recipient continues to qualify and keeps the same policy. Subsidies will phase out with income until the recipient no longer qualifies for Medicaid.

B. The employer of a current Medicaid recipient or guardian who enrolls in an employer-sponsored insurance policy shall receive premium support payments from the **{insert state Medicaid agency}**. Payments will phase out with income until the recipient no longer qualifies for Medicaid.

C. A current recipient or guardian shall have the option to continue the same health insurance coverage, without subsidies.

D. **{Insert percentage}** of any unspent funds in an MSA account, including earnings, shall vest to a Medicaid recipient or guardian who no longer qualifies for Medicaid.

Section 7. Other Uses of Funds for Individuals.

A. A Medicaid recipient may apply in writing to the **{insert state Medicaid agency}** to use MSA funds in excess of any insurance out-of-pocket maximum for education, job training, child care, or other qualifying non-medical expenses.

B. The **{insert state Medicaid agency}** shall respond within seven days to each such request and have a final decision within 30 days.

Section 8. Transparency and Accountability.

A. All transactions involving the state shall be considered public information and posted in an online database after redaction of personal identifying information.

B. The **{insert state Medicaid agency}** shall provide an annual report on cost savings, use of preventive care services, enrollee transition from Medicaid, and other appropriate information.

Section 9. {Severability Clause}

Section 10. {Repealer Clause}

Section 11. {Effective Date}

Passed by the Health and Human Services Task Force on August 7, 2010.

[i] *(Drafting Footnote: If handled through private vendors, it may be worth adding a clause like: "No single vendor shall manage more than [X%] of accounts by value.")*

Resolution on Autism Coverage

Summary

This resolution urges the United States Congress, to add autism bionutritional care as a qualified health expense for health savings accounts, offer tax deductions for families and donors to cover dietary treatment and any recommended therapy, and increase the annual limits on HSA contributions.

Model Resolution

WHEREAS, Autism spectrum disorders are biological disorders of the brain that impair communication and social skills; and

WHEREAS, Autism spectrum disorders affect 1.5 million Americans, including one in 500 children,[i] and autism spectrum disorders may affect as many as one in 67 children; and

WHEREAS, Autism spectrum disorders are more prevalent than spina bifida, cancer, or Down syndrome;[ii] and

WHEREAS, Direct annual costs for autism average $29,000 for medical treatment and behavioral therapies and $38,000 to $43,000 for special education, camps, and child care;[iii] and

WHEREAS, There is no single treatment that works for everyone with autism spectrum disorders; and

WHEREAS, Many aspects of autism spectrum disorders may not be covered by insurance.

THEREFORE BE IT RESOLVED THAT {insert state legislative body} urges the United States Congress to act quickly to

1. Add autism bionutritional care as a qualified health expense for health savings accounts (HSAs);

2. Offer tax deductions for families and donors to cover dietary treatment and any recommended therapy, which would provide similar opportunities to pay for care; and

3. Increase the annual limits on HSA contributions to provide a way for families to finance part of the costs of treatment for their children.

THEREFORE BE IT FURTHER RESOLVED THAT Copies of this resolution be sent to the President of the United States, the United States Congress, and the appropriate leadership of the United States Department of Health and Human Services.

Approved by the Health and Human Services Task Force on July 17, 2009.
Approved by the ALEC Board of Directors on August 27, 2009.

[i] http://www.hsph.harvard.edu/news/press-releases/2006-releases/press04252006.html
[ii] http://www.ncbi.nlm.nih.gov/pubmed/15121991
[iii] http://www.hsph.harvard.edu/news/press-releases/2006-releases/press04252006.html

Resolution on Cord and Placenta Blood Banking Research

Summary

This resolution encourages increased public awareness of umbilical cord blood and placenta-blood banking and donation and acknowledges the positive contributions of private entities who are working to expand umbilical cord blood and placenta-cord banking programs and the researchers seeking to utilize these stem cells for important medical research.

Model Resolution

WHEREAS, Research continues to show umbilical cord blood and placenta-derived stem cells as vehicles for potential treatments of some life-threatening conditions; and

WHEREAS, Stem cells obtained from umbilical cord blood and placenta blood can be used in the treatment of leukemia, multiple myeloma, sickle-cell disease, lymphoma and other terminal illnesses in some patients; and

WHEREAS, These stem cells obtained from umbilical cord blood and placenta blood also are being evaluated for other diseases such as Alzheimer's, Parkinson's, cerebral palsy, diabetes, multiple sclerosis, lung diseases and spinal cord injuries; and

WHEREAS, Research has found that in addition to cord blood, the placenta can yield significantly more CD 34+ stem cells—cells that matter most for transplant success; and

WHEREAS, Research utilizing stem cells from the umbilical cord and placenta is another promising, non-controversial alternative to embryonic stem cell research; and

WHEREAS, Private companies are working to make more umbilical cord blood and placenta-blood banking available to families and to research facilities.

NOW THEREFORE BE IT RESOLVED by **{insert state legislature}**, that the legislature encourages increased public awareness about umbilical cord blood and placenta-blood banking and donation and acknowledges the positive contributions of private entities who are working to expand umbilical cord blood and placenta-cord banking programs and the researchers seeking to utilize these stem cells for important medical research.

Adopted by the HHS Task Force at the Spring Task Force Meeting on April 23, 2010.
Approved by the ALEC Board of Directors on June 3, 2010.

Resolution on Improving Quality and Lowering Costs for States Through Medicaid and Managed Care

Summary

This resolution encourages the implementation of coordinated, risk-based, capitated programs to control costs and improve quality of care for all Medicaid beneficiaries, including those requiring long-term care services.

Model Resolution

WHEREAS, Medicaid is an entitlement program jointly funded by the states and the federal government and plays a significant role in state health care systems; and

WHEREAS, Medicaid is the nation's primary health insurance program for 60 million low-income Americans, including nearly 30 million low-income children and 8 million non-elderly people with disabilities; and

WHEREAS, Medicaid pays for nearly half of all long-term care in the United States; and

WHEREAS, It is essential that Medicaid achieve transformation to become a sustainable, cost-effective health care program; and

WHEREAS, In most states, costs for the Medicaid program are rapidly growing, claiming an increasing share of state budgets and threatening other state programs; and

WHEREAS, Legislators in all states recognize the important role that Medicaid serves as a provider and purchaser of health care services for vulnerable citizens; and

WHEREAS, Under national health care reform, many states will experience an expansion of persons eligible for Medicaid with many of the attendant cost pressures; and

WHEREAS, The situation for individuals under Medicaid with chronic illness and disabilities is particularly fragmented and uncoordinated, with states spending up to 80 percent of their Medicaid budgets on approximately 20 percent of Medicaid beneficiaries whose needs include long-term care services and supports; and

WHEREAS, Reforming and restructuring state Medicaid programs to provide incentives for high quality, efficient and cost-effective care will help contain the growth of the Medicaid program and help ensure that Medicaid does not threaten other essential state services; and

WHEREAS, Managing the care for those with Medicaid through a risk-based system has demonstrated greater budget predictability, more accountability, improved quality of care for the consumer, and more coordination among service providers.

NOW THEREFORE BE IT RESOLVED that the **{insert state legislature}** will seek to strengthen the fiscal solvency of **{insert state}** and improve the health of Americans enrolled

in Medicaid by introducing legislation to implement coordinated, risk-based, capitated programs to control costs and improve quality of care for all Medicaid recipients, including those requiring long-term care services.

Adopted by the HHS Task Force at the Annual Meeting, August 7, 2010.
Approved by the ALEC Board of Directors, September 19, 2010.

Unintended Consequences Prevention Act

Summary

This Act provides that no state department or agency shall implement or enforce any provision of the federal *Patient Protection and Affordable Care Act* unless the department or agency provides a certain report to the legislature, and the legislature authorizes such implementation or enforcement by statute.

Model Legislation

Section 1. Findings. The legislature finds that:

A. **{Insert state}**'s health care system has been developed to address the unique circumstances in **{insert state}** and to provide solutions that work for **{insert state}**; and

B. The federal *Patient Protection and Affordable Care* Act:

1. Infringes on state powers;

2. Imposes a uniform solution to a problem that requires different responses in different states;

3. Threatens the progress **{insert state}** has made towards health care system reform; and

4. Infringes on the rights of citizens of this state to provide for their own health care by:

a. Requiring a person to enroll in a third-party payment system;

b. Imposing fines on a person who chooses to pay directly for health care rather than use a third-party payer;

c. Imposing fines on an employer that does not meet federal standards for providing health care benefits for employees; and

d. Threatening private health care systems with competing government supported health care systems.

Section 2. Model Legislation

A. A department or agency of this state shall not implement or enforce any part of the federal *Patient Protection and Affordable Care Act* unless:

1. The department or agency reports to the legislature in accordance with Subsection B of this section; and

2. The legislature passes legislation specifically authorizing the state's implementation or enforcement of the federal *Patient Protection and Affordable Care Act*, if such implementation or enforcement authority does not already exist.

B. The report required under Subsection A of this section shall include:

1. The specific section of the federal *Patient Protection and Affordable Care Act* that requires the state to implement or enforce a federal reform provision;

2. Whether the reform provision has any state waiver or options;

3. Exactly what the reform provision requires the state to do and how it would be implemented;

4. Who in the state will be impacted by adopting the federal reform provision or not adopting the federal reform provision;

5. The cost to the state or citizens of the state to implement the federal reform provision;

6. The consequences to the state if the state does not comply with the federal reform provision.

Section 3. {Severability Clause}
Section 4. {Repealer Clause}
Section 5. {Effective Date}

Adopted by the Health and Human Services Task Force, December 2, 2010.
Approved by the ALEC's Board of Directors, January 7, 2011.

STATE REIMBURSEMENT FUND ACCOUNT POLICY (WHERE APPLICABLE):

The purpose of the State Reimbursement Fund Account is to provide funding for state lawmakers to attend ALEC conferences, state focus events, and membership events. In those states which allow the establishment of a State Reimbursement Fund Account to be administered by ALEC in Arlington, VA, the Private Sector Chair (where permissible by state law), along with the Public Sector Chair, monitors both contributions and expenditures from that account. The Coordinator of Corporate and Nonprofit Affairs maintains the State Reimbursement Fund account and issues monthly reports of State Reimbursement Fund activity to the regional representatives at ALEC. The regional representatives then provide fund activity to the Public and Private State Chairs and Vice Chairs for their review. Contributions to the ALEC State Reimbursement Fund are tax deductible as ALEC is a non-profit 501(c)(3) corporation. All expenditures from the fund – where applicable – must be approved by the State Chair. No expenditures shall be approved for State Reimbursement Fund Accounts with negative balances. Likewise, no expenditures shall be approved if such will result in the State Reimbursement Fund Account having a negative balance. All disbursements from the ALEC State Reimbursement Fund must be in conformance with all applicable laws, regulations, and rules. Revisions and deviations from this Policy will be made whenever necessary to ensure that the State Reimbursement Fund Account is in full compliance with any applicable law, regulation, or rule.

State chairs must use the template letter with the ALEC logo and the template invoice. The public sector state chair must sign the template letter. Public Sector State Chairs have flexibility to add the signature(s) of the Private Sector State Chair, National Chair or Executive Director. State delegations are encouraged to complete fundraising efforts by the end of the first quarter.

AMERICAN LEGISLATIVE EXCHANGE COUNCIL BYLAWS:

Section 10.07 State Reimbursement Funds.

All funds for ALEC State Reimbursement Funds shall be deposited in accounts designated by the ALEC Legislative Board of Directors. State Chairs are prohibited from establishing, maintaining, or utilizing the accounts. Account expenses can be for ALEC only. Violation of this section shall constitute grounds for (1) immediate removal from a leadership position, and (2) dismissal from membership in accordance with these bylaws.

TRAVEL REIMBURSEMENT POLICY BY MEETING:

Spring Task Force Summit:

1. Spring Task Force Summit Reimbursement Form: ALEC Task Force members are reimbursed by ALEC up to $350.00 for travel expenses. Receipts must be forwarded to the ALEC Policy Coordinator and approved by the Director of Policy.
2. ALEC Task Force Members' room & tax fees for a two-night stay are reimbursed by ALEC.
3. Official Alternate Task Force Members (chosen by the State Chair and whose names are given to ALEC more than 35 days prior to the meeting to serve in place of a Task Force Member who cannot attend) will be reimbursed in the same manner as Task Force Members.
4. State Reimbursement Form: Any fees above $350.00 or for expenses other than travel and

room expenses can be submitted by Task Force Members for payment from the state account upon the approval of the State Chair. Receipts must be submitted to the State Chair who will approve disbursement. However, ALEC has ultimate authority over final disbursement. It is the responsibility of each member, not the State Chair, to mail their signed request to the Coordinator of Corporate and Nonprofit Affairs, ALEC, 2900 Crystal Drive, Suite 600, Arlington, VA 22202.

5. Non-Task Force Members can be reimbursed out of the state fund upon approval. Receipts must be submitted to the State Chair who will submit the signed form to the Senior Director of Membership and Development.

ALEC Annual Meeting:

State Reimbursement Form: State funds are available for reimbursement by approval of the ALEC State Chair. Expenses are reimbursed after the conference and may cover the cost of travel, room & tax, and registration. Receipts must be submitted to the State Chair who will approve disbursement However, ALEC has ultimate authority over final disbursement. It is the responsibility of each member to mail their signed request form to the Coordinator of Corporate and Nonprofit Affairs, ALEC, 2900 Crystal Drive, Suite 600, Arlington, VA 22202.

ALEC States & Nation Policy Summit:

1. States & Nation Policy Summit Reimbursement Form: ALEC reimburses $2,000.00 per state to cover the cost of travel, room & tax, and registration not to exceed $1,000.00 per person for state for new ALEC legislators. ALEC recipients are selected by the ALEC State Chair. Expenses are submitted to the State Chair and reimbursed after the conference. The State Chair submits the signed form to the Senior Director of Membership and Development.
2. State Reimbursement Form: Any other fees or payments must be made out of the state account with ALEC's approval. Receipts must be submitted to the State Chair who submits the signed form to the Senior Director of Membership and Development.

ALEC Academies:

Academy Reimbursement Form: Attendees to ALEC Academies are reimbursed by the Task Force Committee hosting the Academy. Attendees will receive a form at the academy and will be reimbursed up to $500.00 for travel, and room & tax fees for a two-night stay by ALEC. Receipts must be submitted to the State Chair who will approve disbursement. However, ALEC has ultimate authority over final disbursement. It is the responsibility of each member to mail their signed request signed form to the Coordinator of Corporate and Nonprofit Affairs, ALEC, 2900 Crystal Drive, Suite 600, Arlington, VA 22202.Receipts must be forwarded to the ALEC Policy Coordinator and approved by the Senior Director, Policy and Strategic Initiatives.

Mission Statement

To advance free markets, limited government, and federalism.